PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Why do patients seek primary medical care in Emergency Departments? An ethnographic exploration of access to general practice.
AUTHORS	MacKichan, Fiona; Brangan, Emer; Wye, Lesley; Checkland, Kath; Lasserson, Daniel; Huntley, Alyson; Morris, Richard; Tammes, Peter; Salisbury, Chris; Purdy, Sarah

VERSION 1 - REVIEW

REVIEWER	Dr Rebecca Rosen Nuffield Trust London I am also a researcher of primary care/general practice
REVIEW RETURNED	04-Oct-2016

GENERAL COMMENTS	Review of MacKichen et al. *Why do patients seek primary medical care in emergency departments?* This clearly written and well structured paper dissects a highly topical issue in primary care in a novel way. The paper increases the readers understanding of why patients choose to attend ER rather than the GP practices on some occasions, although its final analysis of the implications of the study findings for practical action is a bit disappointing (not clear what enhancing transparency of appointment systems (line 13, p22) or 'imposing ideology on patients' (line 19/20) means. I think they were arguing in the paper that the flexibility to offer different sorts of appointments is what confused patients). That said, their observation that the semantics of urgency vary between patient and provider is challenging and raises interesting questions about how GPs can responds to patient perspectives. Equally the finding that patients don't necessarily get what they want from GPs – particularly in relation to investigations – raises interesting questions about whether emerging GP access hubs and should offer basic near patient testing to meet patient expectations.

	The design of the study is appropriate to its aims and clearly described. Selection methods for choosing practices and interviewees were robust although there is a question about whether 6 practices taken from 3 different deprivation quintiles can provide enough variety to allow broadly generalisable findings. Clearly this cannot be corrected for at this stage. Similarly, with a small number of reception staff interviewees in each site, there is a real possibility of not capturing all behaviours and views but, again, it's not possible to correct for this now. Despite these limitations, I think the study findings are credible. Could the authors add a short description of how they developed the interview guide and of the themes it covered. The themes presented in the results have face validity in terms of capturing the range of issues faced by practices in trying to design appointment systems that respond to patient need and in terms of capturing patient responses to the appointment systems. The use of boxes to present data is effective. The theme of urgency is particularly interesting and I think it merits its own data box – albeit that the theme features heavily in box 5. There is one theme missing from the analysis that is important and should be addressed . This is how the availability of appointments/responses to patient demands for GP access /patient responses to different appointment systems relates to the core capacity of each practice – as measured by the number of doctors per 1000 patients. Anecdotal evidence suggests that with GP ratios of 1:1500 patients, access is much less of a problem. The study practices go above 1:2000. Is there any comment the authors can make about this? Overall, this I found this paper easy to read and interesting with enough novel explanations of patient behaviours in seeking help for urgent problems to merit publication.

REVIEWER	Dr Liz Mitchell Leeds Institute of Health Sciences, University of Leeds, UK
REVIEW RETURNED	30-Nov-2016

GENERAL COMMENTS	This is a useful and timely study that sheds light on some of the reasons behind patients' use of ED for non-urgent care. The paper is generally clear and well written, and makes for an interesting

	read. I have a few comments that will hopefully improve the paper further. Article Summary The bullet points would benefit from a little more detail to contextualise them. Background Lines 35-37: It would be helpful to indicate what the "other, important dimensions of access" are. Lines 48-50: What does "…some studies were limited by their methods of analysis" actually mean? Setting and sampling Table 1: Is it possible to include the rate of ED use for the practices? Why was there such a difference in the amount of time spend observing Practice 1 compared to Practices 4, 5 and 6 in particular? Are there any implications of this in terms of the findings? Analysis It would be helpful to know more about the analysis: did any other members of the ethnography research team contribute to the thematic analysis of field notes (undertaken by EB) and descriptive accounts (undertaken by FM)? Was there double reading and coding, or some other means of contributing to validity? Results The findings are well presented and read well, but there seems to be an over reliance on quotes from certain practices and participants, particularly Practices 1, 2 and 6 for staff, and Practice 4 for patients/carers (8 quotes from 4/8 patients, compared with 1 quote from 6 patients in Practice 1). The findings should be supported by data from a greater number of participants rather than having multiple quotes from the same individuals. There is a quote from Graham, practice manager at Practice 5 (line 47). Presumably this was from an informal discussion; if so, that should be clarified in the text. It might also be worth mentioning in the Methods section how "accurate" informal discussion quotes are: were these documented at the time? General Details of ethical approval should be provided.

REVIEWER	Prof Peter Dolton University of Sussex
REVIEW RETURNED	02-Dec-2016

GENERAL COMMENTS	

Referee's Report on BMJOpen_2016_013816

Introduction.

This paper seeks to address the question of why patients seek primary medical care in ED. The method of investigation is ethnographic exploration.

The interface between GP practices and ED is of crucial importance in the current NHS primary care crisis. The questions posed in this article are central to the problems. The issue with this research is that we learn very little from such small samples based on a unstructured, unsystematic gathering of opinions from very few people. As a result my view is that we learn nothing of value from this study which we can have any confidence in.

Detailed Comments

1. p4 What proportion of ED attendances are self-referred?

2. P4 Rapid access it is claimed in incentivized – how this is not my understanding.
3. No consideration is given to the hour of the day or the day of the week that patients are seeking care.
4. P6. The sample practices characteristics in Table 1 is wholly unrepresentative and the data is from 2009-2012. This is very dated.
5. Table 2 The staff interviews are not a balanced sample of NHS patient facing personnel.
6. Table 3 The patient/carer interviews are not a balanced sample of NHS patients.

General View of the Paper.

The sample is small involving only 29 patients with 'recent use of ED' and a mixture of 19 clinical and non clinical staff across 6 general practices observed for a total of 73 hours. Interview techniques varied between formal and informal unstructured discussion and much of the 'evidence' quoted was simply the personal opinion of one or other individual. Further, the same individual may be quoted at different points in the article which gives more weight to her opinion than can be justified.

Comments made about patients who have 'English as an additional language' are based on 10 surveyed patients, one of whom is a child, who 'do not have English as a first language,' no attempt is made to detail language fluency. Such patients might be professionals working in the UK (and fluent in English) or recent migrants a (whose difficulty navigating the NHS is due to range of issues besides language fluency)

Where people seek urgent medical attention when they believe themselves to be ill is one of the most important current challenges for the NHS. Not only does general practice offer a less expensive service than ED but also effective care planning for individuals with long term conditions which may reduce future need for emergency care. How the frontline, the reception, in general practices functions may well be an important aspect of delivering effective urgent care. Unfortunately this study adds little except further anecdotal evidence in support of this intuitive assumption.

VERSION 1 – AUTHOR RESPONSE

Response to reviewers' comments. Manuscript ID bmjopen-2016-013816

We are very grateful for the evident time and effort the three reviewers committed to our manuscript. Please find a tabulated response to comments below. We have identified the relevant line number in the revised manuscript, where appropriate.

R1		
	Reviewer's comment	Response
1	Final analysis of the implications of the study findings for practical action is a bit disappointing (not clear what enhancing transparency of appointment systems (line 13, p22) or 'imposing ideology on patients' (line 19/20) means. I think they were arguing in the paper that the flexibility to offer different sorts of appointments is what confused patients).	Thank you for theses insightful comments about the implications of the study, which suggest we have not drawn all of them out as well as we might. We have edited the manuscript to simplify and strengthen this section, lines 628-640 *Within individual GP practices (and within primary health care collectively), there is unlikely to be a 'one size fits all' approach to access. Practices in our study were attempting to meet the needs of the majority of their patient population, but in doing so developed complex appointments systems that could inadvertently disadvantage some groups--often those who experienced greater obstacles to accessing care. Priority should be given to simplifying appointments systems and communicating mechanisms to patients, which can help build trust and facilitate equity of access. The burden for negotiating access to care largely falls on GP receptionists, and the complexity of their role demands recognition and adequate support. (34) Active and open engagement with patient perspectives will help General Practice move beyond notions of 'inappropriate' patient-led demand that risk foreclosing avenues for improving access.*
2	Selection methods for choosing practices and interviewees were robust although there is a question about whether 6 practices taken from 3 different deprivation quintiles can provide enough variety to allow broadly generalisable	Although there are variations in the methodological approach, qualitative case studies emphasise depth of understanding of situations/phenomena, with rich and detailed data collected from a small sample. Our sample was carefully selected to maximise diversity in

	findings.	order to capture relevant dimensions of difference between practices. We achieved triangulation by the collection of observational as well as interview data, increasing the depth and rigour of our analysis. It was of note, that, whilst our practices were quite different in their set up and approaches, the issues that arose were recognisable across all sites. We thus reached data saturation. These efforts increase the transferability of our findings beyond the immediate setting. Through interpreting our data and linking it with other literature/research we achieve analytical generalisability, ie, that findings are generalizable to theoretical positions (such as the theory of candidacy, lines 560-565). We do note some limitations in relation to the sampling in the discussion (lines 624-625).
3	A short description of how they developed the interview guide and of the themes it covered.	We have added the following to the manuscript: Page 7 lines 168-171 *Topic guides for staff and patient interviews were developed by the team using a published systematic review (12) and a scoping review of qualitative literature to identify areas to probe. The guides contained a small number of open questions with a list of prompts/probes to facilitate data collection.* Page 7-8 lines 176-179 (specific to the patient interviews) *The topic guide had two parts, the first invited participants to tell the story of their recent ED use (with various probes to elicit detail, from first signs/symptoms to what has happened since the index ED use), and the second invited participants to share their views of their GP practice, with a broad question, "tell me about your GP practice", and prompts to help elicit a full picture.*
4	The theme of urgency is particularly interesting and I think it merits its own data box – albeit that the theme features heavily in box 5.	Thank you for pointing out this interesting and relevant theme. We have included discussion of urgency and provided data to support this under the heading, "Is it an emergency?" In addition to the existing presentation of results under that theme and our discussion, we have amended the title of Box 5 to further bring out the importance of this theme to the general reader.
5	There is one theme missing from the analysis that is important and should be	This issue and didn't emerge as a clear theme in analysis, as such we have not presented it in the

	addressed. This is how the availability of appointments/responses to patient demands for GP access /patient responses to different appointment systems relates to the core capacity of each practice – as measured by the number of doctors per 1000 patients. Anecdotal evidence suggests that with GP ratios of 1:1500 patients, access is much less of a problem. The study practices go above 1:2000. Is there any comment the authors can make about this?	results section of our manuscript. There was not a clear relationship to access and GP: patient ratio from all 6 practices we observed. None of the case study practices had GP ratios as good as 1:1500, and 5 out of 6 had worse ratios than the average for their CCG, yet showed very different levels of appointment availability. Ratios were one clear difference which could have explained a lot of this, but practices also had several other differences. Case 5 (1:1961) had the second lowest ratio but much better appointment availability / access. In order to address this point, we have added the following to the limitations section (line 657-661) *Our study was not designed to test if the ratio of GPs to patients at a practice (one marker of provision of consultation availability) could influence the findings, but there is a possibility that a lower number of GPs for a patient population at a given practice could exacerbate problems with appointment availability.*

R2		
	Reviewer's comment	Response
6	The summary bullet points would benefit from a little more detail to contextualise them.	We have edited the text to give more detail (lines 56-68) • *This in-depth qualitative study helps to explain how interactions in primary health care influence patients' help seeking behaviour and decisions to attend the ED.* • *Our analysis draws attention to modifiable features of primary health care that have the potential to help reduce ED use.* • *We used a qualitative case study approach that involves observation of practice, collection of documentary evidence and individual narratives from patients and providers* • *Patients and carers were invited to participate in the study via their own GP practice. This means that those participating may not be representative of all those self-referring to the ED, and their interviews may be influenced by the method of recruitment (e.g., participants may either have 'an axe to grind' or be reluctant to criticise*
7	Background Lines 35-37: It would be helpful to indicate what the "other, important dimensions of access" are.	We have edited to add (lines 93-94): *, for example access to choice in appointment type or provider, and physical access including availability of GPs and design of premises, (7, 8)*
8	Background Lines 48-50: What does "…some studies were limited by their methods of analysis" actually mean?	We have edited as follows (lines 101-103): *A review examining influences on ED attendance across different health care systems found a differential impact of access to primary care, however some studies were limited by only reporting univariable analysis, which failed to allow for potential confounding factors.(12)*
9	Setting and sampling Table 1: Is it possible to include the rate of ED use for the practices? Why was there such a difference in the amount of time spend observing Practice 1 compared to Practices 4, 5 and 6 in particular? Are there any implications of this in terms of the findings?	Thank you for seeking further clarification on this. ED rates were used to sample practices (high and low) so we were seeking extreme cases, rather than trying to find a smoothly ordered sample encompassing a range of ED usage. Rates of use did not illuminate any of our findings, as determined by multi-professional consensus during research team discussions. Therefore, we have not reported these as they may give an overly simple impression and be unhelpful for the general reader in interpreting our findings. In respect of the time spent in each, this varied as a result of the natural course of data collection. Practice 1 was the first case, and we therefore spent more time there in order to refine our data collection methods and develop our interview topic guides. Furthermore, it was a particularly complex practice with both a walk in service and standard GP practice to observe. As moved through the cases and gained familiarity took less time to reach saturation for a particular case. We don't feel that there are

		implications for this in terms of findings.
10	Analysis It would be helpful to know more about the analysis: did any other members of the ethnography research team contribute to the thematic analysis of field notes (undertaken by EB) and descriptive accounts (undertaken by FM)? Was there double reading and coding, or some other means of contributing to validity?	The entire ethnography team were actively involved in the process of analysis. We have edited the text to provide more detail: Line 185-186: *The field notes were read by EB (with double coding of a selection by LW) to identify themes specific to the practice and also cross-cutting themes* Lines 190-194: *FM wrote an interpretive narrative of each transcript and then integrated these in a descriptive account for each practice that included observational field note data and interview data. The ethnography team met monthly to discuss the ongoing analysis and data collection. This included reviewing and coding raw data (a selection of transcripts and observational field notes) and interpreting descriptive accounts.*
11	Results The findings are well presented and read well, but there seems to be an over reliance on quotes from certain practices and participants, particularly Practices 1, 2 and 6 for staff, and Practice 4 for patients/carers (8 quotes from 4/8 patients, compared with 1 quote from 6 patients in Practice 1). The findings should be supported by data from a greater number of participants rather than having multiple quotes from the same individuals.	The quotes provided are exemplars of a concept, and were chosen as the best fit. Other quotes are less likely to exemplify the point of discussion. There are a few interviewees who are quoted more frequently, which is balanced against the amount of data presented overall, including lots of interactional data from the observations, and use of more detailed narrative, e.g., Mehreen's story in Box 5 (line 555) We have reviewed the balance of quotes and added additional quotes: Patient/carer interview data: Data from Practice 1, 494-499 Data from Practice 2, 363-369; 417-420 Data from Practice 3, 342-345; Data from Practice 5: 345-346; 511-514 Data from Practice 6: Staff interview data Data from Practice 3, 357-358 Data from Practice 5, lines 311 – 312; 341-342
12	There is a quote from Graham, practice manager at Practice 5 (line 47). Presumably this was from an informal discussion; if so, that should be clarified in the text.	Thank you for spotting this. We have edited to clarify (line 360): *In informal discussion, Graham (Practice Manager at Practice 5) suggested that this led patients to frame problems as urgent inappropriately*
13	It might also be worth mentioning in the Methods section how "accurate"	We have edited to add (lines 156-157):

	informal discussion quotes are: were these documented at the time?	*Notes were taken in Informal discussions and detail added immediately afterwards, as necessary.*
14	Details of ethical approval should be provided.	We have now added these to the text (lines 126-127): *Ethical approval was given by the National Research Ethics Committee West Midlands (Coventry and Warwick), study reference 13/VM/0241.*

R3		
	Reviewer's comment	Response
15	p4 What proportion of ED attendances are self-referred?	We have updated to include most recent figures (line 78): *a significant proportion of ED attendances, around 62.8% in 2014-15,(2) are self-referred*
16	P4 Rapid access it is claimed in incentivized – how this is not my understanding.	We have edited to add (line 88): *Rapid access to primary health care in England is incentivised, with reward based on performance in the annual patient survey in primary care (i,e. patient reports of satisfaction with speed of access).*
17	No consideration is given to the hour of the day or the day of the week that patients are seeking care.	We are not sure whether the reviewer is referring to the introduction, or our data. In terms of our study we did attend to this information: both in observations and interviews information was sought and notes made about timing of presentation, and during analysis of observation notes any themes / factors which appeared to be linked to timing were considered. This is not necessarily reflected in our reported findings as the reported findings are not exhaustive (ie, they do not report the entirety of our data), and issues of hour of day/day of week may not have emerged as important in analysis.
18	P6. The sample practices characteristics in Table 1 is wholly unrepresentative and the data is from 2009-2012. This is very dated.	Sampling of cases occurred in 2012-13, so these data were the most recent available for our study. We have added study dates into the manuscript (line 127) for clarity. Sampling in qualitative research is not designed to achieve a representative sample, but instead is typically purposive. In this case, sampling aimed to gain some diversity of GP practice characteristics which previous research suggested were relevant to issues of access. Please also see our response to Reviewer 1 (point 2). We would refer you to these key papers for general discussion of sampling in qualitative research: – Malterud, Kirsti. "Qualitative research: standards, challenges, and guidelines." The lancet 358.9280 (2001): 483-488. (section on 'transferability') – Barbour, Rosaline S. "Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?." BMJ: British Medical Journal 322.7294 (2001): 1115.
19	Table 2 The staff interviews are not a balanced sample of NHS patient facing personnel.	Please see above. The number and range of participants are typical for this type of investigation.
20	Table 3 The patient/carer interviews are not a balanced sample of NHS patients.	Please see above. Patients and carers were purposefully selected on the basis of their healthcare use (they had

		accessed A&E recently), and would therefore not be expected to be representative of NHS patients.

VERSION 2 – REVIEW

REVIEWER	Dr Liz Mitchell Leeds Institute of Health Sciences, University of Leeds, UK
REVIEW RETURNED	06-Mar-2017

GENERAL COMMENTS	I am happy with the responses to my previous comments. The authors might consider adding their response to my comment about the difference in time spent in each practices either to the text or as a footnote to the table.